Effective 5/12/2015

Chapter 11
Health System Reform Act

63N-11-101 Title.

This chapter is known as the "Health System Reform Act."

Renumbered and Amended by Chapter 283, 2015 General Session

63N-11-102 Definitions.

As used in this chapter, "consumer health office" means the Office of Consumer Health Services created in Section 63N-11-104.

Renumbered and Amended by Chapter 283, 2015 General Session

63N-11-103 Duties related to health system reform.

The Governor's Office of Economic Development shall coordinate the efforts of the Office of Consumer Health Services, the Department of Health, the Insurance Department, and the Department of Workforce Services to assist the Legislature with developing the state's strategic plan for health system reform described in Section 63N-11-105.

Renumbered and Amended by Chapter 283, 2015 General Session

63N-11-104 Creation of Office of Consumer Health Services -- Duties.

(1) There is created within the Governor's Office of Economic Development the Office of Consumer Health Services.

(2) The consumer health office shall:

(a) in cooperation with the Insurance Department, the Department of Health, and the Department of Workforce Services, and in accordance with the electronic standards developed under Sections 31A-22-635 and 63N-11-107, create a Health Insurance Exchange that:

(i) provides information to consumers about private and public health programs for which the consumer may qualify;

(ii) provides a consumer comparison of and enrollment in a health benefit plan posted on the Health Insurance Exchange; and

(iii) includes information and a link to enrollment in premium assistance programs and other government assistance programs;

(b) contract with one or more private vendors for:

(i) administration of the enrollment process on the Health Insurance Exchange, including establishing a mechanism for consumers to compare health benefit plan features on the exchange and filter the plans based on consumer preferences;

(ii) the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and others; and

(iii) establishing a call center in accordance with Subsection (4);

(c) assist employers with a free or low cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars;

(d) establish a list on the Health Insurance Exchange of insurance producers who, in accordance with Section 31A-30-209, are appointed producers for the Health Insurance Exchange;
(e) include in the annual written report described in Section 63N-1-301, a report on the operations of the Health Insurance Exchange required by this chapter; and
(f) in accordance with Subsection (3), provide a form to a small employer that certifies:
(i) that the small employer offered a qualified health plan to the small employer's employees; and
(ii) the period of time within the taxable year in which the small employer maintained the qualified health plan coverage.
(3) The form required by Subsection (2)(f) shall be provided to a small employer if:
(a) the small employer selected a qualified health plan on the small employer health exchange created by this section; or
(b)
(i) the small employer selected a health plan in the small employer market that is not offered through the exchange created by this section; and
(ii) the issuer of the health plan selected by the small employer submits to the office, in a form and manner required by the office:
(A) an affidavit from a member of the American Academy of Actuaries stating that based on generally accepted actuarial principles and methodologies the issuer's health plan meets the benefit and actuarial requirements for a qualified health plan under PPACA as defined in Section 31A-1-301; and
(B) an affidavit from the issuer that includes the dates of coverage for the small employer during the taxable year.
(4) A call center established by the consumer health office:
(a) shall provide unbiased answers to questions concerning exchange operations, and plan information, to the extent the plan information is posted on the exchange by the insurer; and
(b) may not:
(i) sell, solicit, or negotiate a health benefit plan on the Health Insurance Exchange;
(ii) receive producer compensation through the Health Insurance Exchange; and
(iii) be designated as the default producer for an employer group that enters the Health Insurance Exchange without a producer.
(5) The consumer health office:
(a) may not:
(i) regulate health insurers, health insurance plans, health insurance producers, or health insurance premiums charged in the exchange;
(ii) adopt administrative rules, except as provided in Section 63N-11-107; or
(iii) act as an appeals entity for resolving disputes between a health insurer and an insured;
(b) may establish and collect a fee for the cost of the exchange transaction in accordance with Section 63J-1-504 for:
(i) processing an application for a health benefit plan;
(ii) accepting, processing, and submitting multiple premium payment sources;
(iii) providing a mechanism for consumers to filter and compare health benefit plans in the exchange based on consumer preferences; and
(iv) funding the call center; and
(c) shall separately itemize the fee established under Subsection (5)(b) as part of the cost displayed for the employer selecting coverage on the exchange.

Renumbered and Amended by Chapter 283, 2015 General Session

63N-11-105 Strategic plan for health system reform.

The state's strategic plan for health system reform shall include consideration of the following:

(1) legislation necessary to allow a health insurer in the state to offer one or more health benefit plans that:

(a) allow an individual to purchase a policy for individual or family coverage, with or without employer contributions, and keep the policy even if the individual changes employment;

(b) incorporate rating practices and issue practices that will sustain a viable insurance market and provide affordable health insurance products for the most purchasers;

(c) are based on minimum required coverages that result in a lower premium than most current health insurance products;

(d) include coverage for immunizations, screenings, and other preventive health services;

(e) encourage cost-effective use of health care systems;

(f) minimize risk-skimming insurance benefit designs;

(g) maximize the use of federal and state income tax policies to allow for payment of health insurance products with tax-exempt funds;

(h) may include other innovative provisions that may lower the costs of health insurance products;

(i) may incorporate innovative consumer-driven provisions, including:

(i) an exemption from selected state health insurance laws and regulations;

(ii) a range of benefit and cost sharing provisions tailored to the health status, financial capacity, and preferences of individual consumers; and

(iii) varying the amount of cost sharing for a service based on where the service falls along a continuum of care ranging from preventive care to purely elective care; and

(j) encourage employers to allow their employees greater control of the employee's health care benefits by providing tax-exempt defined contributions for the purchase of health insurance by either the employer or the employee;

(2) current rating and issue practices by health insurers and changes that may be necessary to achieve the goals of Subsection (1)(b);

(3) methods to decrease cost shifting from the uninsured and under-insured to the insured, health care providers and taxpayers, including:

(a) eligibility and benefit levels for entitlement programs;

(b) reimbursement rates for entitlement programs; and

(c) the Utah Premium Partnership for Health Insurance Program and the Children's Health Insurance Program's enrollment and benefit policies, and whether those policies provide appropriate and effective coverage for children;

(4) providing public employees an option that gives them greater control of their health care benefits through a system of defined contributions for insurance policies;

(5) giving public employees access to an option that provides individually selected and owned policies;

(6) encouraging the use of health care quality measures and the adoption of best practice protocols by health care providers for the benefit of consumers, health care providers, and third party payers;

(7) providing some protection from liability for health care providers who follow best practice protocols;

(8) promoting personal responsibility through:

(a) obtaining health insurance;

(b) achieving self reliance;

(c) making healthy choices; and
(d) encouraging healthy behaviors and lifestyles to the full extent allowed by the Health Insurance Portability and Accountability Act;
(9) studying the costs and benefits associated with:
(a) different forms of mandates for individual responsibility; and
(b) potential enforcement mechanisms for individual responsibility;
(10)
(a) increasing the number of affordable health insurance policies available to a person responsible for obtaining health insurance under Subsection (8)(a) by creating a system of subsidies and Medicaid waivers that bring more people into the private insurance market; and
(b) funding subsidies to support bringing more people into the private insurance market, which may include:
(i) imposing assessments on:
(A) health care facilities;
(B) health care providers;
(C) health care services; and
(D) health insurance products; or
(ii) relying on other funding sources;
(11) investigating and applying for Medicaid waivers that will promote the use of private sector health insurance;
(12) identifying federal barriers to state health system reform and seeking collaborative solutions to those barriers;
(13) maximizing the use of pre-tax dollars for health insurance premium payments;
(14) requiring employers in the state to adopt mechanisms that allow an employee to use tax-exempt earnings, other than pre-tax contributions by the employer, to purchase a health insurance product;
(15) extending a preference under the state procurement code for bidders who offer goods or services to the state if the bidder provides health insurance benefits or a defined contribution for health insurance to the bidder's employees; and
(16) requiring insurers to accept premium payments from multiple sources, including state-funded subsidies.

Renumbered and Amended by Chapter 283, 2015 General Session

63N-11-106 Reporting on federal health reform -- Prohibition of individual mandate.
(1) The Legislature finds that:
(a) the state has embarked on a rigorous process of implementing a strategic plan for health system reform under Section 63N-11-105;
(b) the health system reform efforts for the state were developed to address the unique circumstances within Utah and to provide solutions that work for Utah;
(c) Utah is a leader in the nation for health system reform which includes:
(i) developing and using health data to control costs and quality; and
(ii) creating a defined contribution insurance market to increase options for employers and employees; and
(d) the federal government proposals for health system reform:
(i) infringe on state powers;
(ii) impose a uniform solution to a problem that requires different responses in different states;
(iii) threaten the progress Utah has made towards health system reform; and

(iv) infringe on the rights of citizens of this state to provide for their own health care by:
(A) requiring a person to enroll in a third party payment system;
(B) imposing fines, penalties, and taxes on a person who chooses to pay directly for health care rather than use a third party payer;
(C) imposing fines, penalties, and taxes on an employer that does not meet federal standards for providing health care benefits for employees; and
(D) threatening private health care systems with competing government supported health care systems.

(2)
(a) For purposes of this section:
(i) "Implementation" includes adopting or changing an administrative rule, applying for or spending federal grant money, issuing a request for proposal to carry out a requirement of PPACA, entering into a memorandum of understanding with the federal government regarding a provision of PPACA, or amending the state Medicaid plan.
(ii) "PPACA" has the same meaning as defined in Section 31A-1-301.
(b) A department or agency of the state may not implement any part of PPACA unless, prior to implementation, the department or agency reports in writing, and, if practicable, in person if requested, to the Legislature's Business and Labor Interim Committee, the Health Reform Task Force, or the legislative Executive Appropriations Committee in accordance with Subsection (2)(d).
(c) The Legislature may pass legislation specifically authorizing or prohibiting the state's compliance with, or participation in provisions of PPACA.
(d) The report required under Subsection (2)(b) shall include:
(i) the specific federal statute or regulation that requires the state to implement a provision of PPACA;
(ii) whether PPACA has any state waiver or options;
(iii) exactly what PPACA requires the state to do, and how it would be implemented;
(iv) who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision;
(v) what is the cost to the state or citizens of the state to implement the federal reform provision;
(vi) the consequences to the state if the state does not comply with PPACA;
(vii) the impact, if any, of the PPACA requirements regarding:
(A) the state's protection of a health care provider's refusal to perform an abortion on religious or moral grounds as provided in Section 76-7-306; and
(B) abortion insurance coverage restrictions provided in Section 31A-22-726.

(3)
(a) The state shall not require an individual in the state to obtain or maintain health insurance as defined in PPACA, regardless of whether the individual has or is eligible for health insurance coverage under any policy or program provided by or through the individual's employer or a plan sponsored by the state or federal government.
(b) The provisions of this title may not be used to facilitate the federal PPACA individual mandate or to hold an individual in this state liable for any penalty, assessment, fee, or fine as a result of the individual's failure to procure or obtain health insurance coverage.
(c) This section does not apply to an individual who voluntarily applies for coverage under a state administered program pursuant to Title XIX or Title XXI of the Social Security Act.

Renumbered and Amended by Chapter 283, 2015 General Session

63N-11-107 Health benefit plan information on Health Insurance Exchange -- Insurer transparency.

(1)

(a) The consumer health office shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that establish uniform electronic standards for insurers, employers, brokers, consumers, and vendors to use when transmitting or receiving information, uniform applications, waivers of coverage, or payments to, or from, the Health Insurance Exchange.

(b) The administrative rules adopted by the consumer health office shall:

(i) promote an efficient and consumer friendly process for shopping for and enrolling in a health benefit plan offered on the Health Insurance Exchange; and

(ii) if appropriate, as determined by the consumer health office, comply with standards adopted at the national level.

(2) The consumer health office shall assist the risk adjuster board created under Title 31A, Chapter 42, Defined Contribution Risk Adjuster Act, and carriers participating in the defined contribution market on the Health Insurance Exchange with the determination of when an employer is eligible to participate in the Health Insurance Exchange under Title 31A, Chapter 30, Part 2, Defined Contribution Arrangements.

(3)

(a) The consumer health office shall create an advisory board to advise the exchange concerning the operation of the exchange, the consumer experience on the exchange, and transparency issues.

(b) The advisory board shall have the following members:

(i) two health producers who are appointed producers with the Health Insurance Exchange;

(ii) two representatives from community-based, non-profit organizations;

(iii) one representative from an employer that participates in the defined contribution market on the Health Insurance Exchange;

(iv) up to four representatives from insurers who participate in the defined contribution market of the Health Insurance Exchange;

(v) one representative from the Insurance Department; and

(vi) one representative from the Department of Health.

(c) Members of the advisory board shall serve without compensation.

(4) The consumer health office shall post or facilitate the posting, on the Health Insurance Exchange, of the information required by this section and Section 31A-22-635 and links to websites that provide cost and quality information from the Department of Health Data Committee or neutral entities with a broad base of support from the provider and payer communities.

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